Meeting with Representatives of the County Medical Society and Dr. Meiners
September 9, 2002

Introduction

The purpose of the meeting was to engage the physician community on how to improve acute and long term care services for the elderly and disabled in San Diego. Many of the comments listed below were related to the information that some physicians had received that the County was going to force all Medicare/Medicaid dual-eligibles into managed care sometime very soon. That information was not accurate. The County's LTCIP is still in the planning phase and no service delivery decisions have been made.

I. Participants

Dr. Andrew Alongi
Dr. Richard Butcher
Dr. Rodney Hood
Evalyn Greb, LTCIP staff
Dr. Ben Medina
Dr. Mark Meiners, MMIP
Dr. Rodrigo Muñoz
Dr. Michael Plopper
Dr. Vernon White

II. Discussion Points: In response to how to engage community physicians in this project these were some of the physician responses:

- Managed care in San Diego is large and physicians are sensitive.
- Some are okay with capitation and some are not. There is some question of capitation going away.
- There are many mental health issues: physician experience with the Administrative Services Organization for Public Mental Health currently has the physicians worried about integrating Medicare and Medicaid payments. How will that affect their practice?
- There's also the threat that budget neutrality means fewer dollars for core medical services.
- Medicaid payments are seen as so low that many MDs do not want to participate now.
- For mental health services, Medi-Cal won't pay. Medicare only pays half. Medi-Cal won't pay for hospitalization. Medicare will pay half.
- There are only about 20 psychiatrists who see the bulk of San Diego's Medi-Cal mental health clients.

- In South County, many people are poor and dually eligible. There's also high minority representation in the southern part of the county. With the minority population comes higher co-morbidities.

- The dual-eligibles actually get better care in fee-for-service than managed care because they get unlimited pharmaceuticals.

- Specialty referrals have been limited in Medicare managed care organizations.

- Managed care, as it happens now, will not serve the chronically ill population.

- Many IPAs have failed in San Diego County.

- The Medi-Cal capitated rate is county-wide and not adjusted for chronic-care needs.

- For some physicians, Medicare patients left when they started taking managed care.

- UCSD has a six-month waiting list for specialists under Medi-Cal managed care.

- Physicians reimbursement for Medicare has been cut by about 15% over the last couple years.

- Under fee-for-service a physician can have quick access to a specialist for his patients whereas managed care is a "blind hole".

- Managed care has helped physicians learn protocols for evaluating quality of care such as the number of immunizations and preventive screenings.

- Medicare managed care pharmacy benefits do not cover Alzheimer's medications.

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- They do not want care management at the expense of core medical services.

- Physicians can be in the position of generating extra costs such as multiple referrals to specialists, back and forth, with no controls.

- One opinion was if more dollars were spent on medical care for the elderly that physicians would spend it in the wrong place.

- There are stumbling blocks with transportation gaps, pharmaceutical expenditures.

- Some hospitals have hospitalists so when the patient hits the door, the client is being evaluated for discharge.

- There are physicians in the community who have added office staff to try to attend to some of the social issues such as arranging transportation for patients.

- There is a feeling on part of some physicians that if you have Medicare and Medi-Cal it's the "gold standard" for patients. People who are dually eligible are eligible for the In-Home Supportive program, equipment, medications, skilled nursing facility coverage, and transportation.

- It was stated that there are 2,800 patients for every one physician in southeast San Diego. There are 250 patients for every one physician in the La Jolla area. Most of the patients in southeast San Diego need social services as well as healthcare services. Physicians are paying staff to do some of that but don't get reimbursed.

- It was stated that Medicare and Medi-Cal do not work well together, but it's better than having only Medicare. Several physicians stated that the system could be better.

- Physicians are not in favor of a pharmacy benefit management for the dually eligible. Their feeling is that Medi-Cal pays for any drug they order for a client at this point and that's in the best interest of their patients. The state of California negotiated a deal with drug companies for a great rate in exchange for including all new drugs on the formulary for at least the first 6 months after release.

- It was suggested that integration for a population that uses more resources should be tied to outcomes and funding.

- At the national level, it is know that dual-eligibles are disproportionately costly.

- The Center for Medicare and Medicaid Services at the national level is looking at care management demonstrations for Medicare clients, not yet

for dual-eligibles. Medicare is developing a code for case management.

- One physician stated he would be interested in participating in a demo if the benefits were greater than the problems or the work and if there weren't so many new rules that it made the situation worse and case management service did not move resources from core medical services.

- It was stated that if the concept is to take the dual-eligibles and put them in Healthy San Diego health plans it would be a major mistake. But, if integration provided a different kind of healthcare for the health plans, then it would be supported.

- The question was asked if younger schizophrenics are being included in the "disabled population". About a couple hundred of the young schizophrenics currently are case-managed by the county. Thousands more need care management. It's an extremely vulnerable population and an expensive one.

III. Suggestions/Recommendations

- Physicians would like a couple of full-time case managers at their disposal. However, they do not want it to come out of core medical services' funding.

- They also do not feel the drug benefit should be altered—the Medi-Cal drug benefit under fee-for-service provides total access to script for their patients.

- One physician recommended that a model for poor elderly minority populations also be looked at to choose necessity culturally sensitive quality improvement indicators to be developed.

IV. Next Steps/Action Items

- ✓ Dr. Meiners asked the physicians to think about the kind of interventions that would help their dually-eligibles and the kind of outcomes based results that would be most important to track.

- ✓ Another meeting will be set in the near future to continue the discussion with physicians.